

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

01673

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County HANOVERCity or town WEST FRIENDSHIP
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA County YORKCity or town HANOVER
(If outside city or town limits, write RURAL and give nearest town)Street No. 433 N. HIGH ST
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM U CARBAUGH

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife SALOME CARBAUGH6. (c) If alive, give age 60 years

7. Birth date of

deceased (mo., day, yr.)

9-15-1884

8. AGE:

Years

Months

Days

If less than one day

61425

hrs.

min.

9. Birthplace

PENNA

(Town, county, and state)

10. Usual occupation

PLUMBER

11. Industry or business

BARGEY & SON

FATHER

12. Name

WM H CARBAUGH

13. Birthplace

PA

MOTHER

14. Maiden name

CATHERINE BREIGHNER

15. Birthplace

PA

16. Informant

MRS. W. U. CARBAUGH

Address

HANOVER, PA17. REMOVAL & BURIAL Date thereof

(Burial, cremation, or removal, Which?)

2-11-46

(month) (day) (year)

Cemetery or crematory

ST. MARKS

Location

NEW OXFORD PA

18. Funeral director

F. C. HIGINBOTHAM

Address

ELLCOTT CITY MD

19.

(Date rec'd by registrar)

19. 46

John B. LongmanReg. B.E.E.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 10 19 46 at 11 P. 35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/1019 46, to2/1019 46and that I last saw him 10 alive onno date

19

Immediate cause of death

Cerebral hemorrhage

DURATION

instant

Due to

Hypertensive Vascular Diseasenot known

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Buntz M.D. or other

Address

Ellicott City, Md.

Date signed

2-11-46

RECEIVED
FEB 18 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 945

CERTIFICATE OF DEATH

Reg. Dist. No. 01674 191

1. PLACE OF DEATH

County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hunt Ave. & Columbia Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)Street No. Hunt Ave. & Columbia Pike
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

CHARLES CROSS CHANEY, Sr.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ella M. Chaney

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1883

8. AGE:

Years

Months

Days

If less than one day

62318

.....hrs.

.....min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)10. Usual occupation Supervisor11. Industry or business C & P Telephone Co.12. Name Andrew Richard Chaney13. Birthplace Md.14. Maiden name Sarah Gardner15. Birthplace Md.16. Informant Mrs. Ella M. ChaneyAddress Hunt Ave. & Columbia Pike, Ellicott City17. Burial Date thereof 2/4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Friendship Cem.Location A. A. Co., Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 2/4 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1946, at 430 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 30, 1946, to FEB 1, 1946, and that I last saw him alive on FEB 1, 1946.Immediate cause of death Coronary Occlusion

DURATION

acuteDue to Coronary Heart Disease10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE Geo. A. Kochman M.D.

M. D. or other

Address Ellicott City, Md. Date signed 2/1/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **193**

1. PLACE OF DEATH:
 County Howard
 City or town Florence Md Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Florence Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Denton W Driser **3. (b) Social Security Number**

4. Sex Male **5. Color or race** W **6. (a) Single, married, widowed, or divorced** married

6. (b) Name of husband or wife Maud D Driser **6. (c) If alive, give age** 20 years

7. Birth date of deceased (mo., day, yr.) Oct 3 - 1873

8. AGE: Years 73 Months 4 Days 10 hrs. min.

9. Birthplace Sundarby Ohio
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Denton W. Driser
13. Birthplace Md

14. Maiden name Mary Beall
15. Birthplace Md

16. Informant Maud D. Driser
 Address Woodbine Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 16 - 1946
 (month) (day) (year)
 Cemetery or crematory Damascus Md
 Location Montgomery Co Md

18. Funeral director Robert Barber
 Address Farmville Md

19. Date rec'd by registrar Feb - 16 19 46 Registrar E. Paul Quinn

MEDICAL CERTIFICATION
20. DATE OF DEATH Feb 13 19 46 at 845 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 19 46 to Feb 13 19 46 and that I last saw him alive on Feb 13 19 46

Immediate cause of death Coronary Occlusion **DURATION**

Due to Chronic Endocarditis **1 year**

Due to

Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE C. M. Van Boale M. D. or other
 Address Mt Airy Md Date signed 2/13/46

RECEIVED
FEB 20 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

01678

Reg. Dist. No. 191

1. PLACE OF DEATH:

County HowardCity or town Ellicott City Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Waterloo Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eva B Goodman

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Wm Goodman

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

March 4, 1883

8. AGE:

Years

Months

Days

If less than one day

62109

hrs.

min.

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

Alonzo Pratt

13. Birthplace

Va

MOTHER

14. Maiden name

Sarah Shipley

15. Birthplace

Va

16. Informant

Irene Hudson

Address

Elkridge Md.17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

2-16-46
(month) (day) (year)

Cemetery or crematory

Good Shepherd

Location

Ellicott City, Md.

18. Funeral director

F. C. Kuyubashian

Address

Ellicott City Md19. Feb 16, 1946
(Date rec'd by registrar)

1946

John B. Lingham
John B. Lingham
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 131946, at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 11945

to

Feb 131946and that I last saw him 21 alive on Feb 13 1946

Immediate cause of death

Diabetic Insulin

DURATION

10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

John B. Lingham
Ellicott City Md

M. D. or other

Address Ellicott City Md Date signed 2-14-46

REC'D
FEB 20 1946
BUREAU

ARTISTIAN LEADER

SAG CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Howard
 City or town... Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Waterloo Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Howard
 City or town... Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)

Street No... Waterloo Road

(If rural, give LOCATION)

2. (a) If veteran, name war...

World War #1

3. (a) FULL NAME

John E. Gray

3. (b) Social Security Number

42-05-6233

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elizabeth C. Gray

7. Birth date of

deceased (mo., day, yr.)

May 11th 1896

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

49822

hrs.

min.

9. Birthplace

Ellicott City, Md.

(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

Gas & Electric Co

12. Name

Edward Gray

13. Birthplace

Germany

14. Maiden name

Amelia (Unknown)

15. Birthplace

Germany

16. Informant

Elizabeth Gray

Address

Waterloo Rd. - Ellicott City, Md.

17. Burial, cremation, or removal, which?

Burial

Date thereof

2/6/46

Cemetery or crematory

St. Johns Lutheran

Location

Pfeifers Corner - Howard Co. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul st.

19. Date rec'd by registrar

2-5-46

19. 46

Wm. H. H. H. H.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb. 3 19... 46 at... 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 3 19... 46, to... Feb. 3 19... 46

and that I last saw him alive on

Feb. 3 19... 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

24 min.

Due to

Arteriosclerosis of Cardio-vascular heart disease10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Rothman, M.D.

M. D. or other

Address

Ellicott City, Md.Date signed... 2/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 970

CERTIFICATE OF DEATH

Reg. Dist. No. 0167891

1. PLACE OF DEATH:

County Howard
 City or town Elliott City, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Bella
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Bella Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George W. Hall

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1910

8. AGE: Years 35 Months 2 Day 28 (If less than one day) hrs. min.

9. Birthplace Bella, Md.
 (Town, county, and state)

10. Usual occupation Labour

11. Industry or business

12. Name Caleb Hall13. Birthplace Md.14. Maiden name Hettie Dawson15. Birthplace Md.16. Informant Mrs. Hettie HallAddress Bella, Md.

17. Burial Date thereof Feb. 28, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory National Cem.

Location

18. Funeral director Mrs. Katie R. WilliamsAddress 322 N. Schroeder St19. 26 46 Elliott City, Md.

(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/24 1946, to 2/24 1946
 and that I last saw him alive on no date 19

Immediate cause of death

Coronary Thrombosis

DURATION

1/2 hour

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address Elliott City, Md. Date signed 2/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137

CERTIFICATE OF DEATH

01679

Reg. Dist. No. 190

1. PLACE OF DEATH:

County HowardCity or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2Hospital, institution, or street address where death occurred: ✓How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 1922 Railroad Ave.
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3.(a) FULL NAME

Alaysius W. Hubbard

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 12th 1896

8. AGE:

Years 49 Months 7 Days 21 If less than one day ✓ hrs. ✓ min. ✓

9. Birthplace

Elkridge, Md.
(Town, county, and state)

10. Usual occupation

Res. Paper

11. Industry or business

Self

FATHER

12. Name Charles13. Birthplace Washington, D.C.14. Maiden name Mrs. W. Hubbard15. Birthplace Elkridge16. Informant Mr. Charles F. HubbardAddress 1922 Railroad Ave.17. Burial Date thereof 2/17/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Augustine's Cem.Location Elkridge, Md.18. Funeral director John C. Brown & SonAddress 901-03 Hollins St.19. February 2, 1946 (Date rec'd by registrar)20. Miss E. Bird Williams RegistrarAddress 1609 Main St. ElkridgeDate signed 2/2/46

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1946 at 11:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1946 to Feb 2 1946and that I last saw him alive on Feb 2 1946Immediate cause of death apoplexyLeft HemiplegiaDue to Chronic MyocarditisDue to arteriosclerotic hypertensionOther conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations ✓Date of op. ✓Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓Where did injury occur? ✓ (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ✓Means of injury ✓ Injured at work? ✓23. SIGNATURE W. D. BrumbloughM.D. or other ✓

RECEIVED
FEB 3 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01680

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County..... Howard
 City or town..... Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
 1710 Levering Avenue
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Howard
 City or town..... Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1710 Levering Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Charles Vitalis Hubbard

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 8. AGE: Years..... 46 Months..... 10 Days..... 5 If less than one day..... hrs. min.
 11. Industry or business..... B & O R. R.

9. Birthplace..... Elkridge, Maryland.
 (Town, county, and state)
 10. Usual occupation..... Auditor
 12. Name..... Charles Edward Hubbard
 13. Birthplace..... Martinsburg, West Virginia.
 14. Maiden name..... Sarah Agnes Hudson
 15. Birthplace..... Milford, Delaware.

18. Informant..... Leo C. Hubbard (Brother)
 Address..... 1922 Railroad Ave., Elkridge, Md.

17. Burial..... Date thereof..... 2/13/46.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Mount Airy Cem
 Location..... Elkridge, Md.

18. Funeral director..... John J. Cowan & Son
 Address..... 901-03 Hallway St.
 2/12/46

19. (Date rec'd by registrar) 2/12/46 Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 11, 1946, at 4 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9, 1946, to Feb. 11, 1946,

and that I last saw him alive on February 10, 1946.

Immediate cause of death..... Acute coronary occlusion; myocarditis

DURATION

3 days

Due to..... Post Myocarditis

Duration from history, one month

Due to..... Cerebral

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... 5609 Main Street, Elkridge, Md. Date signed..... 2-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

FILM No. I O C MAR 5 - 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 01681 195

1. PLACE OF DEATH:

County... HOWARD
City or town... CLARKS VILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
near Simpsonville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... HOWARD
City or town... CLARKS VILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No... near Simpsonville
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ALICE CATHERINE KELLY

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced MARRIED
6. (b) Name of husband or wife WM O KELLY 6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) JUNE 20, 1897 1877
8. AGE: Years 68 Months 7 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual occupation AT HOME
11. Industry or business
12. Name REMUS DORSEY
13. Birthplace Md.
14. Maiden name ALICE E CARTER
15. Birthplace Md.

16. Informant WM O KELLY
Address CLARKS VILLE MD
17. BURIAL Date thereof 2-21-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory LOCKST CHAPEL
Location ATHOLTON MD.
18. Funeral director F. C. HIGGINBOTHAM
Address ELLICOTT CITY MD
219/46 Thankshley
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 18 1946 at 8³⁰ A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13th 1946 to Feb. 18th 1946
and that I last saw her alive on Feb. 16th 1946
Immediate cause of death Hypertension -
Cardio-Vascular Disease
DURATION 1 yr.
Due to Arterio-sclerosis -
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thankshley, M.D.
Savage, M.D.
M. D. or other
Address Date signed 2/19/46

RECEIVED
FEB 27 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

Reg. Dist. No. 01682 195

1. PLACE OF DEATH:

County HowardCity or town Beltsville Laurel R.F.D.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 yrsHospital, institution, or street address where death occurred:
Coleville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Beltsville Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No. Coleville
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Elsie Luskline Moore

3.(b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 19198. AGE: Years Months Days If less than one day
26 9 30 hrs. min.9. Birthplace Coleville, Howard Co, MD
(Town, county, and state)10. Usual occupation House maid

11. Industry or business

12. Name Dennis Moore13. Birthplace MD14. Maiden name Fanny Watkins15. Birthplace MD16. Informant Dennis MooreAddress Coleville Laurel R.F.D.17. Buried Date thereof Feb 5 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bacon CemeteryLocation Near Laurel MD18. Funeral director Ridgely SelbyAddress 401 Wash Ave Laurel MD19. 2/5/46 19. Frank Shipley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 8 to Feb 3 1946and that I last saw him alive on Feb 2 1946

Immediate cause of death DURATION

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W B Russell M. D. or overAddress Randall Date signed 2/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DECLINED

FEB 8 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

01683

CERTIFICATE OF DEATH

Reg. Dist. No. 194

FILM No. 100 MAR 4 - 1946

1. PLACE OF DEATH:
County HOWARD
City or town RURAL ELLICOTT CITY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
RFD #2, ELLICOTT CITY, MD
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County HOWARD
City or town RURAL ELLICOTT CITY
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD #2 (near Glenelo, Md)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
AMBROSE WALTER NICHOLS

3.(b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife GERTRUDE CLIFF NICHOLS
6.(c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) January 19, 1899
8. AGE: Years 67 Months 0 Days 27 If less than one day hrs. min.

9. Birthplace CLARKSVILLE, HOWARD CO., MD.
(Town, county, and state)

10. Usual occupation farmer - retired

11. Industry or business farm

12. Name JEREMIAH NICHOLS

13. Birthplace Howard CO., Md.

14. Maiden name ANES MORRIS

15. Birthplace not known

16. Informant Mrs. Gertrude Nichols

Address RFD 2, Ell. City, Md.

17. burial Date thereof 2 / 19 / 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Louis

Location Clarksville, Md.

18. Funeral director F. C. Negretation

Address Ellen City, Md.

19. 2 / 16 19 46 Marie L. Whitaker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 46 at 12:00 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16, 1946 only

and that I last saw him alive on 19 42

Immediate cause of death Coronary artery thrombosis DURATION 3 mins

Due to arteriosclerosis of coronary arteries 5 years

Due to

Other conditions angina pectoris 3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker M.D.

Address Clarksville, Md. M. D. or other

Date signed 2/16/46

RECEIVED
FEB 22 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:

County HOWARD
 City or town RURAL - CLARKSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 57 years
 Hospital, institution, or street address where death occurred:
rural - near Shepherd's Lane
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)
 State MARYLAND County HOWARD
 City or town RURAL - CLARKSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. near Shepherd's Lane
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

ANNIE SCOTT PARLETT

3. (b) Social Security Number

4. Sex 5. Color or race 8. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED

6. (b) Name of husband or wife DAVID PARLETT
(deceased) 8. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) April 12, 18658. AGE: Years Months Days If less than one day
80 10 4 hrs. min.9. Birthplace SIMPSONVILLE, HOWARD CO., MD.
(Town, county, and state)10. Usual occupation HOUSEWIFE11. Industry or business HOME12. Name EDMUND SCOTT PARLETT13. Birthplace BALTIMORE CO., MD.14. Maiden name EMILY GAMBRILL15. Birthplace BALTIMORE CO., MD16. Informant WILLIAM PARLETT (son)Address CLARKSVILLE, MD.17. Burial Date thereof 21 19 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Epithem ChapelLocation Clarksville Md18. Funeral director F. C. HigginbothamAddress Ellicott City, Md19. 2/16 19 46 Marie G. Whitaker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 46 at 8:15/p21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 19 46 to February 16 19 46and that I last saw her alive on February 16 19 46Immediate cause of death Acute cardiac decompensation

DURATION

2 daysDue to arteriosclerotic heart disease5 yearsDue to arteriosclerosis15 yearsOther conditions chronic cholecystitis8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D.

M. D. or other

Address Clarksville, Md. Date signed 2/16/46

RECEIVED
FEB 22 1946
BUREAU T.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 192

1. PLACE OF DEATH:

County..... Howard
 City or town..... near Florence
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 23 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Howard
 City or town..... near Florence
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... R. D. Woodbine
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

MARY E. SHIPLEY

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Widowed
 6. (b) Name of husband or wife..... Joseph V. Shipley
 deceased
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... March 7, 1866
 8. AGE: Years..... 79 Months..... 11 Days..... 7 If less than one day..... hrs. min.

9. Birthplace..... Montgomery Co. Maryland
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business

FATHER 12. Name..... Alexis Trail
 13. Birthplace..... Maryland
 MOTHER 14. Maiden name..... Mary E. Wells
 15. Birthplace..... Maryland

16. Informant..... Mrs. William M. Main
 Address..... Woodbine, Maryland

17. Burial Date thereof..... 2-16-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Jennings Chapel
 Location..... Florence, Howard Co. Maryland

18. Funeral director..... C. M. Waltz
 Address..... Winfield, Md.

19. 2/16 1946 E. Pearl Mercier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 14, 1946, at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Feb 12, 1946, to Feb 14, 1946,
 and that I last saw her alive on Feb 12, 1946.

Immediate cause of death..... Carcinoma of Stomach
 with general metastasis
 DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or Ch.

Address..... Date signed..... 2/14/46

RECEIVED

FEB 20 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01686

CERTIFICATE OF DEATH

Reg. Diat. No.191

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... City or town..... (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....	
3. (a) FULL NAME		3. (b) Social Security Number	
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
6. (b) Name of husband or wife	6. (c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.)			
8. AGE:	Years	Months	Days
If less than one day..... hrs. min.			
9. Birthplace..... (Town, county, and state)			
10. Usual occupation.....			
11. Industry or business			
12. Name.....			
13. Birthplace.....			
14. Maiden name.....			
15. Birthplace.....			
16. Informant..... Address.....			
17. Burial..... (Burial, cremation, or removal. Which?) Cemetery or crematory..... Location..... 18. Funeral director..... Address..... 19. Feb. 24, 1944..... (Date rec'd by registrar)			
20. DATE OF DEATH.....			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to..... and that I last saw him/her alive on..... Immediate cause of death..... Due to..... Due to..... Other conditions..... (Include pregnancy within 8 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work? 23. SIGNATURE..... Address..... Date signed.....			

RECEIVED

MAR 1 1946

BUREAU